Shared Plan of Care Learning Lab Project

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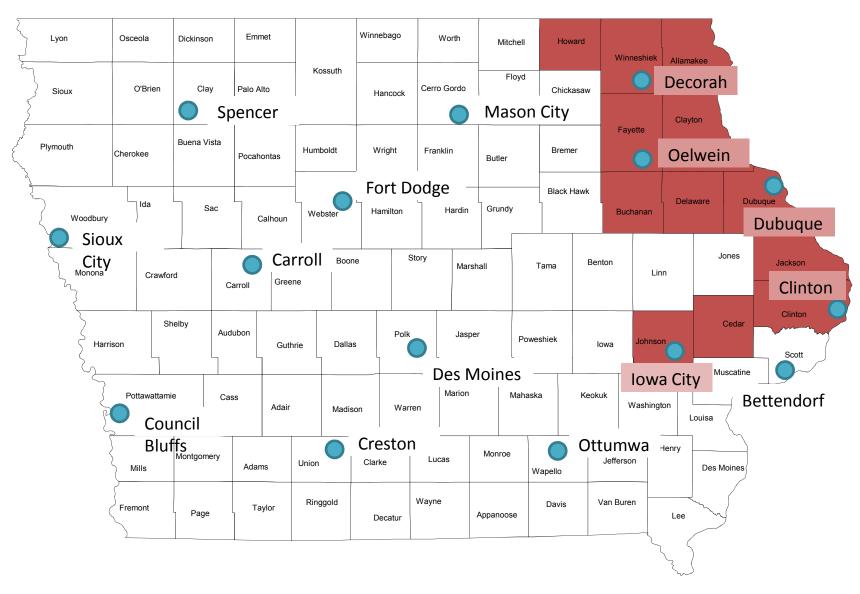


About the Division & CHSC

- Administers Iowa's Title V Program for children and youth with special health care needs, through the federal Maternal and Child Health Bureau
- Network of 14 Regional Centers in communities across Iowa providing care coordination, family support, and clinical services
- Some Regional Centers are Pediatric Integrated Health Home sites: Decorah, Oelwein, Dubuque, Clinton, and Iowa City



CHSC Regional Centers and Pediatric Integrated Health Home Locations



Alignment with Children's Well-Being Core Values, Guiding Principles

Pediatric Integrated Health Home

Community Level: System of Care

Collaboration:

Preparedness; Linkages to services; School based preventive services; Focus on prevention; Early identification: Quality Improvement;

Accessible treatment:

Population health

Collaborative **Agency Partnerships** Accessible Education **Providers Support Services** Improvemen Hospitals Standard Screening Family Care Natural **Processes** Coordination Supports Tele-health **EBP Training** Housing and Services Electronic Healthcare Health Clinical **Systems** Subspecialists Building Care Record Recreational Safe **Supports** Neighborhoods Faith Based Peer to Peer and **Supports**

Family to Family

Support Services

Statewide

Systems

Practice Level: Pediatric Integrated Health Home

> Care coordination: Case management; Individual/family support; Electronic health records: Integration of mental and physical health

State Level:

Workforce development: Payment reform; Health information technology innovations; Data analysis; Resources: State level collaboration, coordination, and monitoring

Systems Integration Grant

- Partnership with Iowa Department of Public Health
- Enhancing a System of Care for Iowa's Children and Youth with Special Health Care Needs (HRSA 14-030)
- Aims:
 - 1. Shared Resource (http://www.iowachildhealthconnections.com/)
 - 2. Integration of Services
 - 3. Cross-Systems Care Coordination



Shared Plan of Care

- Concise yet comprehensive, integrated, and user-friendly compilation of child- and familyspecific information
- Guides care and facilitates its coordination among the family, the child's medical provider and other community partners
- Especially appropriate for kids with complex health needs



Family Engagement at all levels



Policy

Full team members for Development of the Shared Plan of Care concept and template

Provide technical assistance to assure family centered care principles are followed

Family Advisory Council provides feedback at each stage



Community

Assure family-centered care principles are followed

Connect families to family support organizations

Assure collaboration with community and regional service agencies



Individual

Family and youth goals are primary to the shared plan of care Family-to-family support

Family and youth participate in Family Team Meetings

Family-to-family support

Family Feedback



7 of 9 caregivers for pilot families were interviewed about their experience with the SPoC.

- 100% thought the face-to-face meeting was very important and a good use of their time
- Caregivers found the SPoC important as their child grows
- Caregivers of teens appreciated their child being involved in the meeting
- Caregivers reported that updating the SPoC twice a year would be most valuable



Systems Integration Shared Plan of Care Testing Phases

Phase 1 April-June 2016

October-August 2017

Phase 2:

Phase 3: January-August 2017

11 children served by CHSC Pediatric Integrated Health Home (PIHH),stratified as "severe," receiving care at 1 pediatric practice and enrolled in 1 school district

~80 children enrolled in CHSC PIHH program and receiving CMH Waiver services

Children enrolled in CHSC PIHH program and stratified as "severe"





Steps Toward Implementation

- 1. Identify child populations for implementation of the SPoC
- 2. Discuss SPoC with families
- 3. Complete comprehensive assessment
- 4. Work with families to identify goals
- 5. Work with families to identify team members
- 6. Schedule Family Team Meeting
- 7. Complete SPoC with negotiated actions or strategies
- 8. Ensure that the SPoC is accessible, reviewed regularly, and updated



Learning Lab Goals



1. Shared Plans of Care

 At least 80 children/youth and their families enrolled in CHSC's Pediatric Integrated Health Home program

2. Monitor Lessons Learned:

- Family and provider perspectives
- Share Discoveries within the Learning Lab
- Potential for expansion of SPoC implementation to other Pediatric Integrated Health Home programs

3. Discoveries:

- Resource use within PIHH
- Feasibility of studying cost savings through reduced out-ofhome placement, inpatient days, or ER use



Alignment with Children's Well-Being Core Values, Guiding Principles

- Family-driven, youth-guided, strengths-based
- Ensures access to array of community-based services that address emotional, social, educational, physical needs
- Individualized services
- Families and youth are full partners in planning and delivering care
- Services include promising practices



Alignment with Children's Well-Being Core Values, Guiding Principles (cont.)

- Services are integrated at systems level
- Care management integrated at practice level so children and families can move through system of services as needs change
- Continuous accountability incorporated
- Data collection consists of objective facts and informal wisdom-rich information gathered from youth, families, communities



Questions?

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Thank you!

